Programs of All-Inclusive Care for the Elderly (PACE)

Chapter 11 – Grievances and Appeals

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(Rev. 2, Issued: 06-09-11)

10 - Grievances

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

A grievance is defined as a complaint, either written or oral, expressing dissatisfaction with the service delivery or the quality of care furnished.

The PACE organization must have a formal written process to evaluate and resolve grievances, whether medical or non-medical in nature, by PACE participants, their family members or representatives. All personnel (employees and contractors) who have contact with participants should be aware of and understand the basic procedures for receiving and documenting grievances in order to initiate the appropriate process for resolving participant concerns. All participants must be informed of the grievance process in writing upon enrollment into the PACE program and at least annually thereafter.

The PACE organization's grievance process, at a minimum, must include written procedures for the following:

- How a participant files a grievance;
- Documentation of a participant's grievance;
- Response to, and resolution of, the grievance in a timely manner;
- Maintenance of the participant's confidentiality throughout the grievance process and thereafter.

The PACE organization's internal procedures should assure that every grievance is handled in a uniform manner and that there is communication among different individuals who are responsible for reviewing or resolving grievances. In addition, the PACE organization must maintain appropriate documentation so the information can be utilized in the organization's QAPI program.

The PACE organization must discuss with, and provide to the participant, in writing, the specific steps, including timeframes for response, that will be taken to resolve the participant's grievance. It is expected that each PACE organization have a process prepared to acknowledge a beneficiary grievance with timeframes and additional information on the process; for example, a participant grievance form to acknowledge the grievance and a letter of resolution informing the participant of the grievance outcome. The PACE organization must continue providing all required care to the enrolled participant throughout the grievance process. The PACE organization must maintain, aggregate and analyze the information on the grievance process. This information must be utilized as part of the organization's internal QAPI program. Through analyzing the filed grievances there may be an opportunity for process improvement, which could lead to improved quality of care for the participants.

[42 CFR § 460.120; 71 FR 71300 (Dec. 8, 2006)]

20 - Appeals

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

An appeal is defined as a participant's action taken with respect to the PACE organization's non-coverage of, or nonpayment for a service, including denials, reductions, or termination of services.

The PACE organization must have a formal, written appeals process including timeframes for response to address non-coverage or nonpayment of a service. All participants must be provided written information regarding the appeals process upon enrollment, at least annually thereafter, and whenever the IDT denies a request for services or payment. It is expected that each PACE organization have a template prepared to assist the participant in filing an appeal, with written notification to acknowledge that a participant has appealed with the required timeframes and additional information on the process, and a notice of action providing the appeal outcome and information on the next level of appeal.

The information on appeals proceedings will be maintained, aggregated and analyzed by the organization. This process will be utilized as part of the organization's internal QAPI program. Through analyzing the filed appeals, there may be an opportunity for process improvement which could lead to improved quality of care for the participants.

[42 CFR § 460.122(a), (b), and (i); 71 FR 71301 (Dec. 8, 2006)]

20.1 - Internal Processes

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

20.2 - Standard

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The PACE organization's internal appeals process, at a minimum, must include written procedures for:

- Timely preparation and processing of written denials of coverage or payment;
- Filing a participant's appeal;
- Documenting the participant's appeal;
- Appointing an appropriately credentialed and impartial third party who was not involved in the original decision and who does not have a stake in the outcome of the appeal to review the participant's appeal (this may include employees or contractors of the PACE organization through a review committee);

- Responding to and resolving the participant's appeals as expeditiously as the participant's health condition requires, but no later than 30 calendar days after the PACE organization receives an appeal; and

- Maintaining confidentiality of participant appeals.

The PACE organization must give all parties involved in the appeal appropriate written notification and a reasonable opportunity to present evidence related to the dispute in person as well as in writing.

The PACE organization must continue to furnish care to the participant during the appeal process. Specifically, during the appeals process, the PACE organization must meet the following requirements:

- For a Medicaid participant, continue to furnish the disputed services until issuance of the final determination if the following conditions are met: (1) the PACE organization is proposing to terminate or reduce services currently being furnished to the participant; and (2) the participant requests continuation with the understanding that he or she may be liable for the costs of the contested services if the determination is not made in his or her favor.

  Although not required by the regulation, an organization can also furnish disputed services during an appeal for a Medicare participant.

- Continue to furnish to the participant all other required services as specified in subpart F of Part 460.

[42 CFR § 460.122(c), (d), and (e)]

20.3 - Expedited Appeals

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

In addition to the standard appeals process, the PACE organization must have an expedited appeals process in place for situations in which the participant believes that if the service is not furnished, his or her life, health, or ability to regain or maintain maximum function would be seriously jeopardized.

The PACE organization must respond to the appeal as expeditiously as the participant's health condition requires, but no later than 72 hours after it receives the appeal. The 72-hour timeframe may be extended by up to 14 calendar days if the participant requests the extension or the PACE organization justifies to the State Administering Agency the need for additional information and how the delay is in the interest of the participant.

The PACE organization must take appropriate action to furnish the disputed service as expeditiously as the health condition of the participant requires if, on appeal, a determination is made in favor of the participant.

The PACE organization is required to notify CMS, the State Administering Agency, and the participant of its determination that is wholly or partially adverse to a participant at the time the decision is made. CMS notification may be accomplished through the HPMS Data Element for monitoring reporting.

[42 CFR § 460.122(f), (h), and (g)]

20.4 - Additional Appeal Rights Under Medicare or Medicaid

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The external appeals process provides participants with an appropriate external review depending on their Medicare and Medicaid status. Medicare beneficiaries have access to the Medicare external appeals route through the Independent Review Entity (IRE) that contracts with CMS, while Medicaid-eligible individuals have access to the State Fair Hearing process. In those cases where participants are covered only under one program (Medicare or Medicaid), only the applicable appeals process would apply. PACE participants who are dually eligible for both Medicare and Medicaid have the choice of either process, however, they may only choose one route by which to exercise their external appeal rights. Allowing dually eligible participants to choose to pursue an appeal through either the Medicare's IRE or Medicaid's State Fair Hearing processes eliminates the possibility of conflicting determinations. Therefore, all PACE participants have one route by which to exercise their external appeal rights. A PACE organization must inform a participant in writing of his or her appeal rights under Medicare or Medicaid managed care, or both, assist the participant in choosing which to pursue if both are applicable, and forward the appeal to the appropriate external entity.

The PACE organization must continue to furnish the disputed services to the participant during the appeal process because Sections 1894(a)(1)(B)(i) and 1934(a)(1)(B)(i) of the Act requires that participants receive benefits solely through the PACE organization and, as explained in 42 CFR § 460.98(a), the required services for a participant are those services identified in their plan of care.

[42 CFR § 460.124; 71 FR 71303 (Dec. 8, 2006)]

20.5 – Medicare-Only

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

Medicare does not have an external appeals process that permits challenges of enrollment denials or disenrollment determinations for Medicare-only beneficiaries within PACE. A Medicare-only eligible participant will need to use the appeals process that States are required to provide for enrollment/disenrollment decisions.

More information on the Medicare IRE process is available online at http://www.medicareappeal.com.

[71 FR 71303, 71312, and 71317 (Dec. 8, 2006)]

20.6 - Medicaid

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

Information regarding the State Fair Hearing process can be obtained from the State Administering Agency. States can determine whether the participant can bypass the internal appeals process and go directly to the State Fair Hearing process.

The PACE organization must continue to furnish disputed services to Medicaid participants until the appeal is complete.

If the decision is unfavorable to the participant, the participant would be responsible for the cost of the disputed service.

The PACE organization must be sensitive to the State Fair Hearing time constraints to ensure that the participant's rights to access the State Fair Hearing are not negated by failure to meet the State timeframes.

[42 § CFR 431.200 thru 431.250; 71 FR 71302 and 71304 (Dec. 8, 2006)]

Transmittals Issued for this Chapter

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